Januaray 16, 1987

Enclosed are copies of the Task Forces' reports on reorganization of Maryland state government. The reports have been adopted with minor modification by Governor-Elect William Donald Schaefer and Lt. Governor-Elect Melvin A. Steinberg.

The minor modifications adopted after consultation with the Chairmen of the Task Forces are listed below:

Task Force on Economic Development and Housing Y3 H084:2/C/987

1. Under Federal law, the WIN Demonstration Program must be administered by the state welfare agency, therefore, it will remain in DHR.

2. Defer moving the Building Codes function to the Department of Licensing and Regulation until the new Secretary of Housing can review this further.

Task Force on the Environment and Chesapeake Bay Y3 EN61:2/F/987

1. The name of the new department will be the Department of the Environment.

2. There are some changes in the functions to be pulled out of DNR as per attached chart.

Task Force on Health Y 3 HE44:2/F/987

1. The Juvenile Service Administration will be reconstituted as an independent agency with an Executive Director directly responsible to the Governor, rather than a cabinet level department.

2. The Secretary of the new Department of Health and Mental Hygiene will be provided with additional deputies in order to better administer the department.

Md Y 3 Ad 6/1:2/F/987

Governor-Elect William Donald Schaefer

Announces He Will Recommend Reorganization of

Four State Executive Departments

Baltimore - (January 19, 1987) Governor-Elect William Donald Schaefer announced today he will recommend reorganizing four of the state's executive departments to better serve Maryland Citizens.

Schaefer's plan was revealed in a briefing on reorganization held by his transition team. The plan is the culmination of an intense 11-week study of state departments affecting economic development, housing, the environment, the Chesapeake Bay, health and juvenile services. The study was conducted by three task forces appointed by Schaefer, November 5, the day after the general election.

Schaefer will incorporate his reoganization plans in legislation which he will submit on Friday to the state legislature. The decision to submit legislation rather than an executive order was made following recommendations from the state legislators.

"The business of state government is to serve people," said Schaefer. "As I traveled the state last year, the state's citizens complained that many times a plodding, overlapping bureaucracy was the problem rather than the solution to essential difficulties. Better coordination and organization, they said, would shape up state government. They were right! The reorganization recommendations I will submit later this week will enable state government to better serve Marylanders and solve pressing problems."

"

Md. Y 3.2:En 6/1.21/1987

The most significant proposals Schaefer will recommend are summarized below:

-To assure the aggressive protection of our precious air and water resources, Schaefer will recommend consolidation of the environmental and regulatory enforcement program into one streamlined agency called the Department of the Environment. These programs are now diffused throughout state departments.

-To guarantee protection of our prize natural resource, the Chesapeake Bay, Schaefer will appoint a special gubernatorial coordinator who will be directly accountable to him. The Governor's Office of Chesapeake Bay Coordinator will make one person with direct access to the Governor responsible for Bay programs.

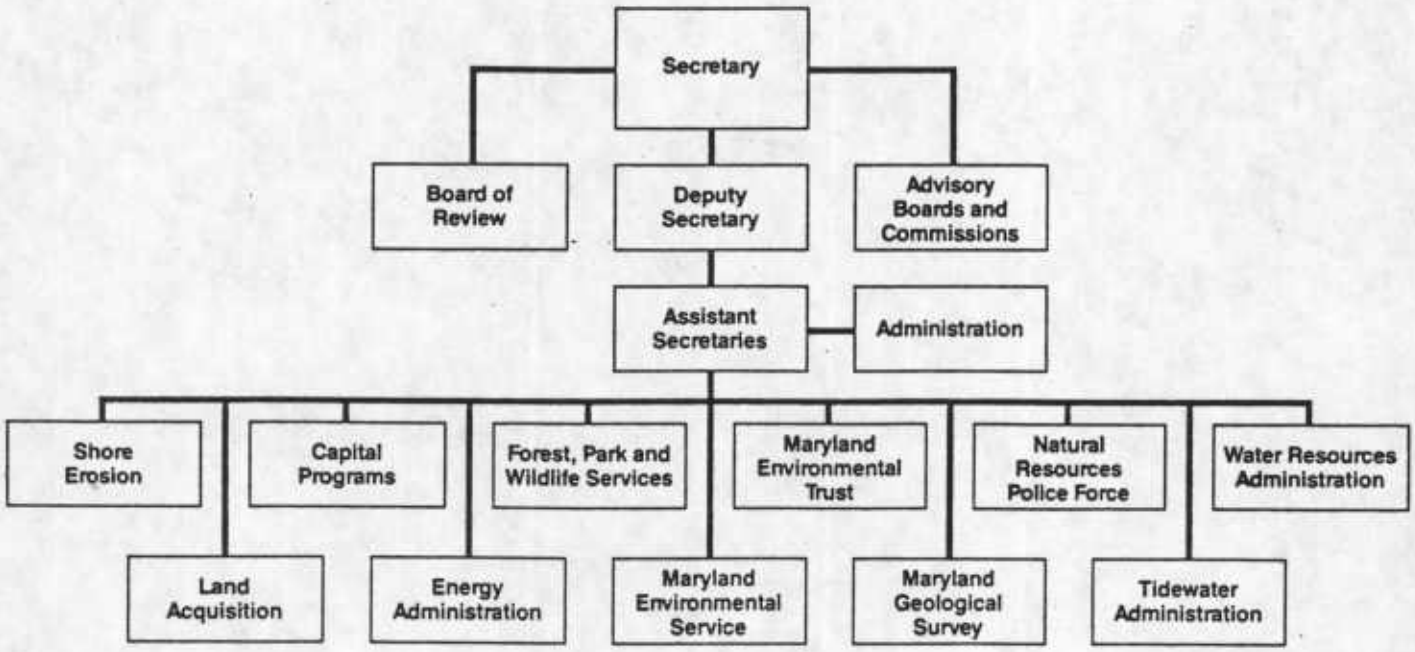
-To establish a stronger, more dynamic statewide system of juvenile justice, I will move the Juvenile Services Administration out of its current stepchild status and transfer it into the Governor's Office as an independent agency directly under the Governor.

-To highlight the importance of housing and to assure Marylanders increased opportunities for decent, affordable shelter, Schaefer proposes elevating the Housing and Community Development Agency--currently an arm of the Department of Economic and Community Development--to cabinet standing.

Along with this recommendation, the Governor will propose consolidating the state's employment and training programs into a division of the restructured Department of Economic Development. By tying training programs directly to the department responsible for job creation and expansion, the state will be able to best assure adequate employment opportunity for its citizens.

Proposed Changes
Department of Natural Resources

Existing
Department of Natural Resources



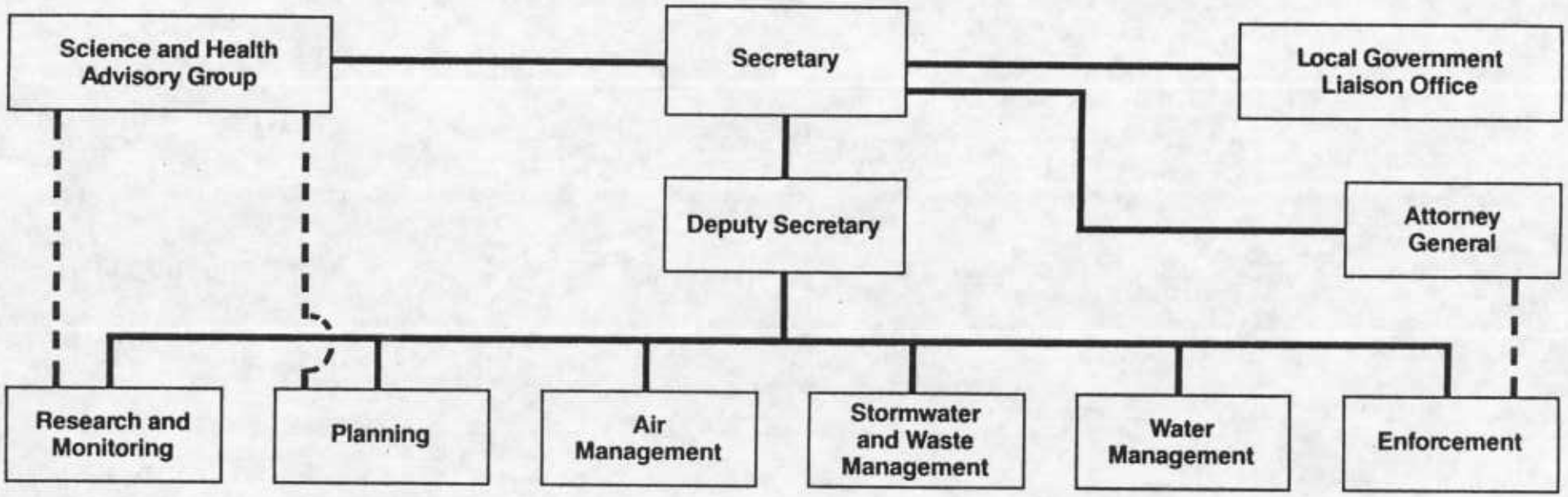
Maryland
Energy Office

Transferred
to Proposed
Department
of Housing

- Oil Management Program
- Stormwater and Sediment Control Program
- 1987 & 1988 Budget Items for Bay Related Research

Transferred
to Proposed
Department of the
Environment

Proposed
Department of the Environment



- Monitoring
- Quality Control
- Research
- Modelling
- Liaison with Scientific Community
- Interagency Coordination

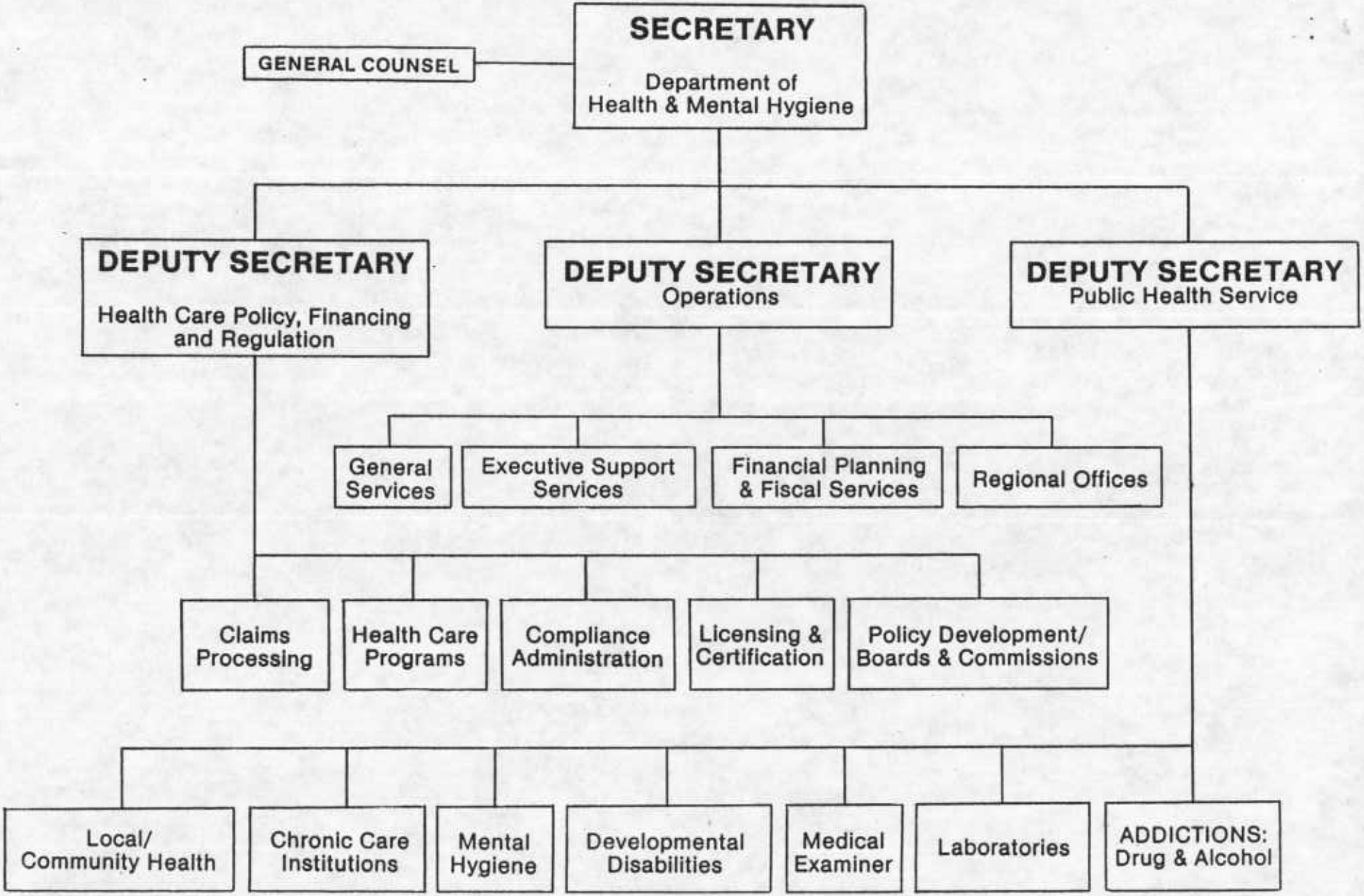
- Watershed Planning
- Program Evaluation
- Coordination of Department's Bay Programs
- Policy Development
- Public Information and Education

- Permitting
- Inspections
- Compliance Monitoring

- NPDES Industrial
- Oil Control
- Stormwater and Sediment Control
- Waste Disposal
- Compliance Monitoring
- Inspections

- Construction Grants
- NPDES Municipal
- Compliance Monitoring
- Inspections

- Intradepartmental Coordination of Enforcement
- Interagency Coordination
  —Agriculture
  —DOT
  —DNR


SECRETARY
Department of Health & Mental Hygiene
GENERAL COUNSEL
DEPUTY SECRETARY
Health Care Policy, Financing and Regulation
DEPUTY SECRETARY
Operations
DEPUTY SECRETARY
Public Health Service
General Services
Executive Support Services
Financial Planning & Fiscal Services
Regional Offices
Claims Processing
Health Care Programs
Compliance Administration
Licensing & Certification
Policy Development/ Boards & Commissions
Local/ Community Health
Chronic Care Institutions
Mental Hygiene
Developmental Disabilities
Medical Examiner
Laboratories
ADDICTIONS: Drug & Alcohol

Final Report of Task Force on Health

January, 1987

REPORT OF THE GOVERNOR-ELECT'S TASK FORCE ON HEALTH

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EXECUTIVE SUMMARY

The Governor-elect's Task Force on Health has examined the impact of the Department of Health and Mental Hygiene's organizational structure on its ability to make policy and deliver services. On the basis of testimony from witnesses and its own investigations, the Task Force recommends that the following four steps be taken.

1. The Juvenile Services Administration should be removed from DHMH and established as a Cabinet-level Department of Children and Youth (DCY). The State Advisory Board of Juvenile Services, which is now appointed by the Secretary of Health and Mental Hygiene, should be reconstituted as the State Advisory Board to the Department of Children and Youth, with its members appointed by the Governor. For the present time, the new Department should serve the same population as the current agency. We believe that the full-time attention of a Department Secretary and the accountability and visibility of independent status will do much to revitalize the delivery of juvenile services in Maryland. Simultaneously, DHMH will benefit from a major reduction in its Secretary's span of control. We suggest that the new Department take a number of initiatives, including the establishment of a facility and program designed to treat chronic juvenile offenders.

2. The proposal of the Task Force on Environment and the Chesapeake Bay to transfer DHMH's Office of Environmental Programs, with the exception of the Community Health Management Program, to a new Department of Environmental Protection should

be implemented. We also endorse the Task Force on Environment's proposed arrangements for providing the Department of Environmental Protection with access to DHMH laboratories. Additionally, we propose that the Boards of Environmental Sanitarians, Well Drillers, and Waterworks and Waste System Operators, which are currently housed in DHMH, also be transferred to the Department of Environmental Protection. We believe that these actions, by reducing the Secretary's span of control, will result in a more manageable and effective DHMH.

3. The Task Force recommends that the Governor establish an Office of Health Policy as part of his staff. The Office should study and make recommendations on the major issues which Maryland must address in the immediate and long-term future if its citizens are to continue to receive cost-effective and high quality health care. Given the enormous demands of its operational responsibilities, DHMH cannot be expected to fully address these issues. The Governor should also appoint a Health Policy Advisory Council, to perform an advisory role in his and the Office of Health Policy's deliberations over these issues.

4. The Task Force believes that DHMH can and should be more efficiently structured. However, our time-constrained review of the Department has not provided us with an adequate basis for recommending major changes beyond those proposed above. Accordingly, we recommend that, immediately upon the transfer of JSA and OEP, the Department undertake a thorough study

of how it should be organized in the future so as to facilitate more effective management and delivery of services. Additionally, we encourage the Governor to consider which of the 29 regulatory boards, commissions, and councils currently housed in DHMH should remain there and whether the relationship between the Secretary and boards which do remain in the Department should be revised. Similarly, the organizational location and relationship with the Secretary of DHMH's 21 citizens advisory boards; 20 advisory boards, commissions and councils; and numerous task forces mandated by statute should be reviewed.

INTRODUCTION

On November 8, 1986 the Governor-elect's Task Force on Health was charged with developing a plan for the restructuring of the Department of Health and Mental Hygiene in order to reduce the Secretary's span of control and create a more manageable entity. In working to meet this charge, the full Task Force met eleven times between November 17 and December 18. During these meetings, testimony was heard from 18 witnesses who are listed below in alphabetical order.

Joe Adler, Executive Director, Maryland Classified Employees Association

Dr. Joyce Boyd, President, Conference of County Health Officers and Local Health Officer for Kent County

Judge John Carroll Byrnes, Circuit Court for Baltimore City

Darrell Cammock, President, Health Facilities Association of Maryland

Fred Chew, Executive Director, Health Facilities Association of Maryland

Hal Cohen, Executive Director, Health Services Cost Review Commission

John Colmers, Deputy Director, Health Services Cost Review Commission

Charles Fisher, Chairman, Health Services Cost Review Commission

Gary Furham, Chairman, Governor-elect's Task Force on Environment and the Chesapeake Bay

Dr. Susan Guarnieri, Baltimore City Commissioner of Health

Larry Lawrence, Executive Director, Maryland Hospital Association

Roger Lipitz, President, Meridian Healthcare

Ruth Massinga, Secretary of Human Resources

Douglas Morgan, Assistant Secretary of Health and Mental Hygiene for Medical Care Programs

Dr. David Rogers, Local Health Officer for Howard County

Mary Ann Saar, Executive Assistant to Governor-elect Schaefer

Carl Sardegna, President, Blue Cross and Blue Shield of Maryland

Adele Wilzack, Secretary of Health and Mental Hygiene

The Task Force and its individual members also received numerous written and verbal reports from DHMH and other knowledgeable parties, Task Force subcommittees met for work sessions and to hear additional testimony, and the Task Force's staff member gathered additional data.

As a result of its studies, the Task Force's attention was quickly drawn to four span of control questions and one overriding question of public policy. These questions concern:

1) the appropriate organizational location for DHMH's Office of Environmental Programs;
2) the appropriate organizational location for the Juvenile Services Administration;
3) the appropriate organizational location for Medical Care Programs, the Health Services Cost Review Commission and the Health Resources Planning Commission;
4) the functional organization of DHMH, and;
5) the way in which Maryland's health policy is to be made during a period of major transition in the way health care services are delivered.

After long debate, the Task Force's members unanimously recommend the following actions to the Governor-elect:

1) Transfer of DHMH's Office of Environmental Programs, except for the Community Health Management Program, to a new Department of Environmental Protection.
2) Removal of JSA from DHMH, and its re-establishment as a Cabinet-level Department of Children and Youth.
3) Letting of a contract to a professional management consultant for a thorough study of how the streamlined DHMH should be organized to best meet the challenges of the future.
4) Creation of an Office of Health Policy in the Governor's Office.

The Task Force carefully considered whether to recommend, as a fifth step, that Medical Care Programs, the Health Services Cost Review Commission and the Health Resources Planning Commission be removed from DHMH and established as an independent department. Our unanimous recommendation is that such an action not be taken. We are convinced that the interaction between Medical Care Programs and other DHMH programs is far too close and valuable to be disturbed. Although the Medical Care budget is large, it is almost entirely composed of pass-through money and is operated by less than 3% of DHMH's employees. Furthermore, the Secretary's span of control is not lengthened by the presence of the two regulatory commissions within DHMH, since they operate as independent entities by virtue of Maryland statutes. We believe, however, that their location within DHMH for administrative and budgetary purposes also serves to foster a useful interchange of ideas with DHMH's various administrations.

The Task Force would be negligent if it failed to note that in preparing its recommendations it did not closely examine their fiscal implications. While we believe that our recommendations will ultimately have a positive impact on the state's expenditures for health services, we recognize the necessity of examining their administrative costs prior to a decision on implementation. Our recommendations have been provided to the appropriate Transition Team members for this purpose.

Finally, the Task Force would like to note that it has collected a large amount of information in support of its

conclusions which does not appear in this report. We would be pleased to make this information available upon request.

THE JUVENILE SERVICES ADMINISTRATION

The Governor-elect has charged this Task Force with determining whether the Secretary of Health and Mental Hygiene's span of control is too broad. We believe that it is, and that the Juvenile Services Administration's performance has suffered as a result. Restoring public confidence in JSA, revitalizing its management and more clearly defining its mission will demand the continuous attention of an executive at the highest level of government. It is not reasonable to expect the Secretary of DHMH to be this person -- DHMH operates too many other programs, faces too many other controversies, and has a health-oriented mission which does not fully mesh with JSA's mission. Therefore, the Task Force recommends that JSA be removed from DHMH and established as a Cabinet-level Department of Children and Youth (DCY). The State Advisory Board of Juvenile Services should be reconstituted as the State Advisory Board to the Department of Children and Youth, with the appointing authority transferred from the Secretary of Health and Mental Hygiene to the Governor.

Accountability for the quality of juvenile services will be more clearly focused than is presently the case if JSA is given independent status. We believe that this will help stimulate a needed reformulation of the organization's objectives. Well-defined objectives are an essential prerequisite of management's ability to direct all agency efforts toward effective program design and implementation. Independent status will also increase JSA's visibility and enhance its

communications with the State's executive, judicial and legislative leaders. This is another essential prerequisite for the organization's revitalization.

The Task Force is aware of the danger of further fragmenting the State's government. If problems of this nature arise, though, they are likely to be significantly outweighed by the benefits which will accrue from an independent, revitalized DCY. Furthermore, JSA's position in DHMH has not resulted in adequate cooperation between it and the other administrations, which have resisted viewing JSA's clients as part of their responsibility. Secretary Wilzack, as part of her Special Needs Children and Youth Initiatives, has done much to begin reversing this situation and to bring about an acknowledgment within DHMH that the multiple problems which beset many youths prevent one administration from providing all needed services. We do not wish to see these useful steps undermined, and do not believe that the administrative separation of JSA from DHMH will have this effect. The Secretary of DHMH and the Secretary of DCY should enter into detailed cooperative agreements to maintain on-going relationships (with the exception of administrative functions to be transferred to DCY), which are specified in the appendix to this report. All relationships between JSA and other DHMH units which are operated on a purchase of care basis can and should be continued where desirable. DHMH services currently available without charge to all youths who meet eligibility requirements will remain available to DCY clients who meet those requirements.

The Department of Children and Youth should, for the present time, serve the same population as the current agency. The centerpiece of this agency would be a comprehensive, individualized assessment of each referred child. (Currently, only children at risk of being removed from their homes by the Court are assessed -- this assessment is often inadequate.) This assessment should not be premised on a particular "approach" to "the juvenile problem"; rather, it should place each youth in the preventive, habilitative or rehabilitative program appropriate to his or her particular needs. Post-assessment programs would be delivered in various settings and range from counseling to overnight care to residential facilities providing an array of services. Services not provided for in the cooperative agreements with DHMH would be directly operated by DCY, brokered for, or purchased from other government agencies and the private sector. In many cases, brokering or purchasing may be superior to direct operation, and will avoid needless duplication of services.

The reconstituted agency must take four major initiatives. First, it is imperative that chronic juvenile offenders not waived into the adult system be identified and placed in an appropriately structured facility and program. Neither JSA nor the Department of Public Safety and Corrections is currently well-suited to handle chronic juvenile offenders. New approaches to the chronic juvenile offender problem are mandatory if we are to make a serious impact on juvenile and adult crime rates and provide these youths with an opportunity to avoid wholly tragic lives. It is recommended that the reconstituted

DCY Advisory Board be tasked to establish guidelines for identifying chronic juvenile offenders and structure an appropriate program and facility. This work must be done in close collaboration with the new DCY leadership, the judiciary, and appropriate members of the Governor's staff. It is the Task Force's expectation that the existence of such a facility and program will reduce the severity of the problem which judges now face when deciding on the discretionary waiver of juveniles into the adult justice system. It is our hope that if this program proves its value by operating successfully, the question of automatic waiver for certain offenses can be reviewed.

Second, DCY should place far greater emphasis than JSA now does on preventive programs. In Fiscal Year 1987, JSA allocated only 5% of its $75 million budget to prevention.

Third, DCY should reallocate its resources, or use newly-obtained resources, to develop a personnel and program evaluation capability. Information generated by this system could be used to improve performance in many ways. For example, it might serve as the basis for proposals to develop greater flexibility of job classifications within the merit system.

Fourth, the new Department of Children and Youth should serve as the focal point for coordinating services offered to its clients by all other departments and agencies. In order to effectively perform this function, the organization's management information system will have to be upgraded more extensively and more quickly than is currently planned. Developing a capability which will allow DCY access to critical

data about their clients' involvement with a limited number of programs operated by DHMH and other departments will produce significantly improved performance.

In the event that our recommendation is not accepted, we support retaining JSA in DHMH. It should not be transferred to another department, such as Public Safety and Corrections or Human Resources. Neither Department would offer as hospitable an environment to JSA or as much experience in delivering the broad range of juvenile services as DHMH.

The Task Force would like to conclude this section of its report by suggesting an agenda for the future. The practical and ethical importance of making special efforts to help each child build the beginning of a decent life cannot be overstated. Therefore, as the DCY matures consideration should be given to enlarging its scope to include comprehensive services for all children and youth who need services that cannot be obtained from or through their families. Several physical, psychological, emotional and behavioral problems often burden the same child. However, children receiving services move from program to program and department to department without adequate tracking and coherent planning. A Department of Children and Youth able to offer and integrate all of the services necessary to treat the child as a whole has much potential for improving on current outcomes.

ENVIRONMENTAL PROGRAMS

The Task Force on Health endorses the proposal of the Task Force on Environment and the Chesapeake Bay to transfer DHMH's Office of Environmental Programs, with the exception of the Community Health Management Program, to a new Department of Environmental Protection. Accordingly, DHMH's Assistant Secretariat for Environmental Programs should be abolished. The Community Health Management Program should be assigned to an appropriate location within DHMH by the Secretary.

The Task Force on Health also endorses the Task Force on Environment's proposals for organizing the DHMH laboratories and the environmental sections of the Local Health Departments to meet the needs of both DHMH and the Department of Environmental Protection.

Additionally, the Task Force on Health proposes that the Boards of Environmental Sanitarians, Well Drillers, and Waterworks and Waste System Operators, which are currently housed in DHMH, also be transferred to the Department of Environmental Protection.

The Task Force on Health believes that these actions, by reducing the Secretary's span of control and sharpening the focus of DHMH's mission, will result in a more manageable and effective DHMH.

Developing Health Policy for the State of Maryland

During the last decade and a half, the State of Maryland has been one of the nation's leaders in developing health policy aimed at controlling the escalating costs of medical care, providing all of its citizens with equal access to needed medical care, and rationalizing the building and use of hospitals and other health facilities.

The last five years have been a time of marked change in the way medical services are organized and financed in Maryland and the remainder of the United States. The competition for patients and dollars among physicians, hospitals and other health care providers has become intense. Changes in the marketing of health insurance to employer groups and in the delivery of health services through managed care programs (such as Health Maintenance Organizations and Preferred Provider Organizations) have affected the medical marketplace profoundly. Corporate and labor leaders have been unanimous in demanding that health care costs be controlled. Consumers are increasingly given choices through their employers between traditional indemnity insurance and managed care programs of all types. Medicare's change from cost-based to Diagnostic Related Group-based prospective payment, along with changes in the commercial and private insurance industry, has led to a marked decline in both hospital admissions and patients' average length-of-stay. Technologic change has virtually eliminated some procedures that formerly required hospitalization and shifted increasing amounts of surgical, diagnostic,

and therapeutic medical care to outpatient settings. Finally, tne Federal government seems certain to make further Medicare and Medicaid budget cuts and payment mechanism changes.

Maryland has moved into an era of competition among providers while simultaneously retaining major elements of a closely regulated medical care delivery system. These changes bring into question the state's ability to maintain the all-payer system. One of this system's functions has been to make it possible for hospitals and other providers to care for the poor.

Many of the Task Force's witnesses testified that a continuing re-examination of Maryland's health policy is essential for successful adaptation to this new environment. An agenda of critical issues facing the State includes the following:

1. Health Care for the Poor and Underinsured

Uncompensated care in the State's hospitals has increased by 104% over the last four years. This places in jeopardy the hospitals' ability to continue providing care for the uninsured and underinsured. This problem has certainly been exacerbated by Medicaid's failure to increase eligibility limits for the poor and, most importantly, by the State Medicaid program's payment policies.

The uninsured and underinsured now include a substantial number of employed persons and the elderly, as well as the unemployed poor. How will their health care be financed?

2. Competition vs. Regulation

In an era of competition between providers, what is the role of regulation in ensuring citizens' continued access to appropriate health care? Which services, if any, should be provided on a regional, non-competitive basis. Burn and trauma services, along with certain highly specialized services such as transplantation, are among the services which should be examined in light of this question. In a price competitive environment, it is possible that access to and quality of care will be adversely affected. How can the State assure that the quality of health services delivered at every level meets a set of minimum standards?

What is the appropriate mix of regulation and competition in the State of Maryland?

3. Long-Term Care and Care of Patients with Catastrophic Illness

Long-term care for the elderly has been, and will continue to be, a growing need. More than 40% of Maryland's Medicaid budget is currently consumed by expenditures for long-term care. What is the best way to meet this need? Do home health services or other alternatives need expansion?

What is the best way to provide comprehensive, continuous care to the elderly? How will we deal with the increasing problem of financing care for patients with catastrophic illness?

4. Graduate Medical Education

Through patient charges, the citizens of Maryland fund most of the cost of educating interns, residents and

other health professionals in the State's teaching institutions -- mainly the University of Maryland and Johns Hopkins Hospitals. Continuation of this funding mechanism is jeopardized by changing patterns of hospital reimbursement.

What should State policy be with respect to the funding of graduate medical education?

5. Special Health Problems -- AIDS

The consequences of the AIDS epidemic will put an increasing strain on budgetary and hospital resources. It will also create additional demand for long-term nursing home and hospice care. To date, there have been over 450 active AIDS cases diagnosed in Maryland. By 1990, 500 additional cases per year are expected. Since the average cost per case in the U.S. has been approximately $50,000, expenditures on new AIDS cases could amount to $25 million per year. This is in addition to expenditures on previously diagnosed cases. As treatments become available during the next several years, the cost per case could increase substantially.

It is imperative that the State address this issue promptly and begin to put in place the necessary physical and professional resources. How will the State respond to this need?

6. Deinstitutionalization

Deinstitutionalization of the chronically mentally ill has been State policy. For many individuals, it has worked well. However, approximately 30% of the homeless and street people were formerly institutionalized.

How can Maryland provide an effective community care system for this population?

These problems and others of equal importance must be addressed by the State.

The mechanisms for developing health policies which respond to the changing health care environment and successfully cope with the problems specified above must be strengthened, made more visible, and institutionalized in State government. The Department of Health and Mental Hygiene (DHMH) has attempted to address some of these issues. However, these efforts generally have been conducted on an ad hoc basis. The day to day management of a large, diverse department which must respond in timely fashion to multiple demands makes it very difficult for the Secretary and other top-level officials to give policy development the attention which it now desperately needs. DHMH administers Medicaid and a variety of other categorical programs for health services. Through the independent Health Services Cost Review Commission and Health Resources Planning Commission a regulatory mechanism is provided. But it has not been possible for DHMH to consider all elements of the health care delivery system simultaneously, despite the fact that the private and public sectors are inextricably woven together in that system.

In order to fill this gap in policymaking, the Task Force recommends that the Governor establish an Office of Health Policy as part of his staff. This Office should be headed by a knowledgeable, high-level health professional, who

will be assisted by a small staff. All Office of Health Policy personnel, including the director, will serve at the Governor's pleasure. Staff may be recruited from outside the present State government and/or detailed from other organizations in the State government, such as DHMH's policy analysis units. The Office will interact as is deemed necessary and desirable by the Governor with the governmental and private agencies involved in the health care system.

Maryland is fortunate to have a large in-state pool of health care experts. In order to take advantage of this resource and to insure that the concrete needs of health care consumers and providers are fully understood, the Task Force also recommends that the Governor appoint a Health Policy Advisory Council (HPAC) to advise himself and the Office of Health Policy. The HPAC should be composed of 13 knowledgeable and representative persons, including the following: a chairperson; two members of the General Assembly; one health care provider, one third-party payer, one consumer and three other members from among these groups; the Secretary of DHMH; the Chairman of the Health Services Cost Review Commission; the Chairman of the Health Resources Policy Commission; and the Insurance Commissioner.

ADMINISTRATION OF DHMH

Implementation of the Task Force's recommendation that JSA, OEP and three regulatory boards be removed from DHMH would result in the transfer of approximately 2,300 personnel, $110 million in appropriations, and the lead responsibility for performing two major functions to other Departments. We believe that this will result in a considerably more manageable and better focused Department of Health and Mental Hygiene.

The Task Force recommends that the 26 regulatory boards, commissions and councils which will remain in DHMH following removal of the three environmental boards be thoroughly studied. We have not had an opportunity to review each of these bodies, but it is clear that some are not functionally related to DHMH and should be transferred to the Department of Licensing and Regulation. Other regulatory boards and commissions, such as Medical Discipline, have a close relationship to DHMH's mission and major issues of health policy. These should be retained in the Department. The relationship between the Secretary and boards and commissions which remain in the Department, methods of staffing these boards, and alternative mechanisms for performing the boards' functions should be considered. DHMH's 21 citizens advisory boards; 20 advisory boards, commissions and councils; and numerous task forces mandated by statute should be subjected to a similar review.

The Task Force has chosen not to recommend any other changes in DHMH's internal organization and structure. We believe that the Department can and should be more efficiently

structured. The need for a more efficient structure will increase if our recommendation for the creation of a Governor's Office of Health Policy is accepted, and as the Department meets the challenge of implementing new policies. However,the Task Force does not believe that its time-constrained review of DHMH's structure has provided an adequate basis for proposing major changes. Accordingly, we recommend that, immediately upon the transfer of JSA and OEP to new Departments, a thorough study should be undertaken of how the Department of Health and Mental Hygiene should be organized in the future. We further recommend that this study include, but not be limited to, the following issues:

1) Should the Department's Assistant Secretariats be organized under a Deputy Secretary for Policy and a Deputy Secretary for Operations?
2) How have the Department's numerous policy planning and analysis units performed and related to one another?
3) Would it be useful to streamline the current organization of DHMH's programs for family planning, hereditary disorders, maternal and child health, and adolescents?
4) How can the Department's capability to effectively implement its programs through the Local Health Departments be maximized?

5) In what, if any, areas should job classifications be revised in order to improve program performance?

6) How can DHMH's management information systems be improved?

7) Would it be useful to transfer any of the licensing programs operated by DHMH's line administrations to the State's Department of Licensing and Regulation?

8) How can the number of DHMH officials serving in an acting capacity be reduced?

ACKNOWLEDGEMENTS

The Task Force's members would like to express their appreciation to all those who contributed their time and expertise to our deliberations. In addition to the witnesses listed in the Introduction, this included the many public servants and private citizens who communicated with us informally. Without exception, they are working to improve the quality and cost-effectiveness of the health care provided to the citizens of Maryland.

The Task Force's members feel a special obligation to thank the following persons for their assistance: Secretary of Health and Mental Hygiene Adele Wilzack and Mary Stuart, John Staubitz and Jennifer Robbins of her staff; Judge George Rasin; Ernie Kent, the Transition Team's Liaison to the Task Force; Richard I. Smith, the Task Force's staff member; and Marie King. All of these individuals have enriched the quality of this report, but none are responsible for its conclusions.

APPENDIX

DHMH ADMINISTRATIONS'
SERVICES TO JSA

JSA/DAA

- DAA has implemented a project to train intake workers in identifying youth with substance abuse problems and how and where to refer youth (i.e. DAA treatment programs) (Differential Treatment Project).

- DAA has provided training and set up formal links between JSA intake and drug treatment programs. Project piloted at two offices in Baltimore City and DAA ready to go city wide. This will allow immediate referral of substance abuse cases to treatment programs in Baltimore City (1,200 juveniles).

- DAA set up a Job Readiness/Decision-Making program currently treating 120 adolescents at Hickey School. DAA has funded staff for program.

- DAA/JSA are jointly funding the establishment of three new group homes for adolescents with substance abuse problems (total 38 in FY 1987). DAA is funding two homes and JSA is funding one home.

JSA/ACA

- ACA and JSA have developed links for interagency training; sharing client assessments; and interdisciplinary assessment teams.

- ACA through grants will be expanding treatment beds for JSA - 15 in FY 1987.

- Finan Center - Lois Jackson Unit: Services to JSA youth with alcohol and drug problems; a 40 bed unit located at a MHA facility. JSA, DAA, and ACA all contribute funds to Unit.

- JSA/ACA/LHA have implemented a joint training effort to train intake workers to identify youth with an alcohol problem and refer appropriately.

- ACA is funding through the Baltimore City Health Department a substance abuse counseling position for Montrose.

- ACA is funding through Baltimore City Health Department a consultant group at Montrose to do substance abuse counseling.

- ACA/DAA training unit conducted a survey of youth at Montrose and Hickey to identify substance abuse problems.

JSA/PMA

- PMA received federal Maternal and Child Health Block Grant funds to implement a special project to assist JSA in developing a data system for health care needs; training for staff; use data base to begin planning. One of only two such programs in the country.
- PMA started health services program for youth centers in Western Maryland - PMA funds a grant to the Allegany Health Department for provision of health services to youth centers.
- PMA provides on-going nursing consultation to JSA youth on health care.
- PMA nursing staff is working with JSA assessment teams and have standardized health assessment forms and intake forms.

MHA/JSA

- Eastern Shore Consortium of Residential Services (MHA, JSA, DSS, DOE) is developing a special treatment center on the Eastern Shore for JSA youth with serious emotional problems. MHA will be providing clinical component; DOE will provide education services.
- Therapeutic Groups - MHA has identified JSA youth eligible for therapeutic group homes for emotionally disturbed youth and have set aside beds for these youth. MHA is funding the beds.
- MHA is entering into "shared service agreements" with JSA group homes to provide mental health services to youth in those group homes - agreements include methods of reimbursement, population served. The mental health services will be provided by MHA outpatient clinics.
- MHA will develop and operate through a contract a unit for seriously emotionally disturbed JSA youth at Hanover Complex - MHA funded.
- Noyes Center (JSA detention)/Regional Institute for Children and Adolescents - Montgomery - MHA provides maintenance and food services to JSA.

JSA/Assistant Secretary for Administration

- The AS:A provides JSA with a number of administrative and technical services. These include:
  - Technical assistance in developing a management information system and in improving the current system.
  - Engineering and maintenance technical expertise in providing to all JSA facilities and group homes.
  - Planning and Capital Budget Development
  - Accounting

JSA/Medical Care Programs

- JSA/MHA/MCP are implementing Medicaid reimbursement for services provided at Good Shepard, a residential treatment facility for JSA females. MHA may provide independent assessments for youth through MH clinics.